Speech-Language Pathology Services

#1015-7495 132 Street, Surrey, B.C., V3W 1J8 604-503-2832
admin@beehivetherapy.com www.beehivetherapy.com

Client Personal Information/Case History

(Please note: this information will be kept confidential)

Name:	**Date of Birth:**
Address and Postal Code:	**School/Profession:**
Email Address:	**Phone number:**

Today's date: ____

Person completing this form: _________________________________

Referred by: ____

Doctor's name: ____

1. Please describe your communication difficulties:

____

____

2. When was the problem first noticed?

____

____

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3. Who first noticed the problem?

____
____

4. Have you consulted other professionals about the problem? (circle one)
   Yes **No**

If yes, please describe:

____
____

5. Have you had any speech-language or hearing *evaluations/assessment*?
   (circle one) **Yes** **No**

If yes,

When? ____

Who/where? ____

What were the results?

____
____

6. Have you received prior speech-language or hearing therapy? **Yes** **No**

If yes,

When? ____

Who/where? ____

What were the results? ____

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FAMILY HISTORY

Has anyone in your family had speech-language difficulties (parents, siblings, etc.)? **Yes** **No**

If yes, please describe:

____

____

____

ASSOCIATED SERVICES

Have you seen an Occupational Therapist, Physiotherapist, Psychologist, Behavioural Consultant or other relevant professional?

____

____

Thank you for completing this form.